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A SUGGESTION RELATIVE TO CLASSIFYING NERVOUS AND MENTAL DISEASES.*†

LOWELL S. SELLING, M.D.

Since experiences are only of value when they can be compared, classifications are necessary in all sciences. To consider each case as an unreproduced experience in its entirety places the psychiatrist at a disadvantage for he does not know what has happened to similar cases and what has been learned in the past from the symptoms which are presented.

By the same token psychiatric experience is not separable from any other medical experience, and with its growth as a science various new shades of mental abnormality are being studied. The neurologist and the expert in child guidance, as well as the psychologist, pathologist, and physiologist, have all contributed to a better understanding of psychiatric problems, but while individual psychiatrists have taken advantage of these contributions, they have not, as a group, given them recognition. Neurology is largely classified according to the anatomical changes present and the mental functions are considered only as symptoms. In child guidance, the tendency has been to base classification on etiology. In legal medicine and custodial psychiatry, symptoms without regard to their anatomical bases have been stressed. It is obvious, nevertheless, that no one of these angles is more important than any other.

In the past numerous methods have been used to classify nervous and mental diseases. In pre-Kraepelinian days mental diseases were classified according to the type of symptoms which were manifested or according to concomitant medical findings. For example, Griesinger listed states of mental depression, comprising slight melancholia, melancholia with stupor, melancholia (suicidal and homicidal) and agitated melancholia; a class which he calls "mental exaltations" includes "mania" and "monomania." "States of mental weakness" comprise such entities as "chronic mania", "dementia", "apathetic dementia", idiocy and cretinism; while general paralysis and the neuroses are to him only complications. A contemporary etiological classification includes such entities as: general paralysis; paralytic, traumatic,

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epileptic, syphilitic, rheumatic, gouty, phthisical, and uterine, ovarian, masturbational insanities. With the formulation by Kraepelin of the distinction between the recoverable and non-recoverable psychoses, a step forward is made in classifying mental disorders as due to infection, exhaustion, intoxication, as being thyrogenous, or as dementia praecox, dementia paralytica, organic, involutional, manic-depressive, paranoia, epileptic insanity, psychogenic neurosis, constitutional psychopathic states, psychopathic personalities, defective mental development.

Dr. Kempf in 1919 suggested grouping neuroses as follows: suppression, repression, compensatory, regression and dissociation types, subdivided into benign and pernicious types.

Dr. Charles Mercier gave the following criteria for classification in 1904: He states that the classification

a) Should represent and embody the general state of our knowledge at the present time.

b) Should receive general approval and support.

c) Should be sufficiently elastic to be adaptable to future discoveries.

d) Easy of application by all sorts and conditions of alienists.

e) Must distinguish differences that are patent, manifest and free from doubt.

f) Be expressed in terms generally agreed upon or defined in a sense that will be generally accepted.

g) Include all things that we seek to classify.

h) Classification in our sense is the distribution of things into classes; the like together and the unlike apart. Insanity is one and indivisible. It is not kinds of insanity, but cases of insanity we are to classify.

i) The scission of each class must proceed upon a single principle—(1) Causation (alcoholic insanity); (2) underlying morbid change (general paralysis); (3) nature of associate (epileptic insanity); (4) course of disease (oflie circulaire); (5) dominant symptom (fixed delusion); (6) time of origin (congenital imbecility); (7) intensity of disease (acute delirious mania).

j) Single principle may differ for each class, or each subdivision.

k) First division must eliminate causation, pathological anatomical basis and course of disease.

l) There remains predominant symptom, time or origin, intensity of disease.

When such criteria as the foregoing are applied to classifications similar to the 1917 classification of the American Psychiatric Association, they fail, and for this reason the writer has given consideration to the possibility of classifying nervous and mental diseases from a somewhat different angle.

In addition to Mercier's criteria, the following points should be observed:

1. The descriptive title of each division should be as simple as possible and should represent the exact findings or basis of the condition.
2. Minor disorders should have as important a part in a classification as the psychoses, for psychiatry no longer limits itself merely to diagnosis and commitment of the insane.
3. The system should be so constructed that contributions from other fields of medicine can be included.
4. The system should be so constructed that the only requirement for its use would be a knowledge of the field and the ability to observe symptoms, and to recognize what lies behind them.
5. Terms should be defined and where possible criteria should be deliminated for each term.
6. Main heads should be as brief as possible, but should be arranged in such a manner and with so great care that the subheads can cover every point involved.

In order to make a satisfactory classification there are three rules of division which must be adhered to. First, each division must be exhaustive but there should be nothing that is included in the class of objects which is being divided that can be omitted from the separate genera into which it is divided. Secondly, each different class must

be mutually exclusive, and thirdly, each division must be based upon one fundamental process of division.

In the older classifications all of these rules are violated. In the American Psychiatric classification, which is being used with various modifications at the present time, we have no categories except those listed under the terms "without psychoses," or "psychoses unclassified" in which to include atypical conditions. It is within the experience of all of us to have had psychopathic patients who did manifest typical symptomatology of any of the conditions listed under the psychiatric classification or which presented symptoms which were characteristic of a different disease. For example, the writer calls to mind a case which was brought into the psychopathic ward of a large hospital. It was that of a man who had been in a building at the time it collapsed. He had periodical episodes about five minutes apart for the first two hours after his admission. During these episodes he saw beams falling upon him, a repetition of his frightful experience. He was obviously not suffering from one of the major psychoses for his mental condition cleared up in a few hours. His mental state could not be classified as a "transient state of excitement" for he was not excited. It might have been called a "transient hallucinosis" but yet he was able to say immediately after each attack that his experience was not hallucination.

The second fallacy, that of making a class co-ordinate with another class which should be subordinate to it, is readily illustrated by the eleventh and twelfth groups in the present classification which are "psychoses with pellagra" and "psychoses with other somatic diseases." Why these two should be made coordinate one does not know, and why co-ordinate divisions five, six, seven and eight should be "psychoses with cerebral syphilis", "with Huntington's chorea", "with brain tumor" and "with other nervous diseases" is not self-evident. A much nearer approach to a logical and useful classification is suggested by that in use in Germany at the present time. The first two large divisions are "Allogenous" and "Somatogenic", but, unfortunately, such main groups as those of "psychoses with brain injury", "manic depressive psychosis", "paranoia", and similar diagnostic entities are placed co-ordinate with these two big heads.

The third fallacy is the fallacy of cross division, since some divisions are classified according to disease entities and some according to symptoms. We are all familiar with the fact that involutional melancholia and the depressed states of the manic depressive psychosis have similar symptoms and yet are probably on an entirely different

bases. While giving each a separate division appears to be a simple escape from the problem, it fails to show the relationships. From another point of view, psychoses with somatic diseases are classified according to the disease, which the schizophrenias and affective psychoses are classified according to symptoms.

One cause of the presence of all of these fallacies lies in the use of terms which mean very little, which are archaic, and in many cases not descriptive. No one has attempted to express himself as to the exact distinction between schizophrenia and dementia praecox, and whether they include all introverts or not. The terms themselves possibly require clarification before any real ordination of them can be carried out.

The first suggestion that the writer might make would be to have all of the conditions which are considered to be entities in psychiatry carefully defined. Those definitions should be lgical definitins, which would indicate the large group in which the term is used and the factors which are known which would set it off from other members of the group.

When properly classifying the elements and variants from which our psychiatric patients are studied, including the behavior disorders of childhood, the criminal and the case with some neurological symptoms, we must face the following facts:

1) A classification in which all of the single term disease entities are listed, whether co-ordinately or subordinately, is unsatisfactory, because it does not show causes when symptoms are stressed and vice verse.

2) Another weakness lies in the fact that prognosis is only implied.

For the proper understanding of a medical case it is imperative that one should know the knowledge of its causation, its characterization, its anatomical basis, and its general course. The New York Tuberculosis and Heart Association has spent a great deal of time in classifying heart disease and tuberculosis. The system used in its classification of heart diseases is applicable to mental disorders but in a slightly different manner. There are four divisions used:

1) Classification according to etiology.
2) According to structural changes.
3) According to functional changes.
4) According to prognosis.

The etiological and prognostic categories without further justification in mental disorders can well stand, but so far as symptomatology is concerned, distinction between structure and function is an artificial one. It would be better to list the type of structural damage as one division, and a functional characterization rather than a demonstration of functional changes as the other. The formal divisions in such a classification would be:

1) Etiology.
2) Functional syndromes or symptomatological groupings.
3) Structural representation (tissue involved and manner of tissue involvement).
4) Prognosis.

At the beginning of this century it would have been impossible to justify the structural categories for our knowledge of tissue changes was so slight, but even in disorders such as dementia praecox which we still classify as functional, Spielmeyer and others have shown organic changes. When one considers the number of conditions which are no loner considered functional, there is great justification for including structural change as a main division, and it is the writer's opinion that progress in neuro-histology and pathology will tend to fill in the gaps in this group rapidly. So far as the functional or descriptive section is concerned, if it is kept purely on a descriptive basis, conflicting schools of psychiatry can still use such a classification even though they differ greatly about the interpretation. A rough tentative classification would be as follows:

I. Etiological
  A. Predisposing causes
    1) Hereditary influences
    2) Congenital defects
      a) Blastopthoria
      b) Individual susceptibility
    3) Birth influences due to
      a) Physical trauma
      b) Psychic birth trauma
    4) Structural weakness due to
      a) Diseases of childhood
        1) Bacteriological
        2) Chemical
        3) Physical cause (except trauma)
      b) Diseases of adolescence

1) Bacteriological
2) Chemical
3) Physical cause (except trauma)

c) Adult diseases
1) Bacteriological
2) Chemical
3) Physical cause (except trauma)

5) Traumatism
a) To nervous system
b) To contributing systems

6) Social
a) Familial
1) Parental relationships
2) Sibling relationships
3) Parent-sibling interrelationships

b) Secondary group
1) School
2) Associates
3) Physical environment
4) Financial situation
5) Community standards

c) Indefinite

B. Exciting causes
1) Trauma
2) Infection (list varieties)
3) Toxic agents (list agents)
4) Social change or pressure due to
a) Familial situation
b) Engironmental situation
c) Economic situation
5) Unknown

II. Functional
A. Without change
B. Mnemic syndrome
1) Amnesia
a) Confabulation
b) Without confabulation
c) Disorientation
1) Complete
2) Partial

2) Paramnesia

C. Sensory syndrome
   1) Blindness
      a) Peripheral
      b) Central
   2) Deafness
      a) Peripheral
      b) Central
   3) Et al.

D. Ideational syndrome
   1) Delusional syndromes
      a) Hallucinations
      b) Without hallucinations
   2) Delusional syndromes
      a) Deterioration
      b) Without deterioration

E. Associational syndrome
   1) Distractibility
   2) Inhibition
   3) With changes of content
      a) Lessening
      b) Accentuation
   4) Dream-like states
   5) Diffuseness and circumstantiality

F. Affective syndrome
   1) Hyperaffectivity
   2) Hypoaffectivity
   3) Irritability
   4) Instability
   5) Apathy
   6) Egocentricity
   7) Perversion
   8) Deterioration

G. Intellectual syndrome
   1) Perversion
   2) Deficient capacity

H. Suggestibility syndrome
   1) Inhibitory
   2) Hypersuggestible

I. Motor syndrome
   1) Restlessness
   2) Destructiveness
   3) Uncontrolled impulses
   4) Excitement
J. Behavior variants
K. Unclassified

III. Structural syndromes
A. Without change
B. Cardiac
C. Respiratory
D. Digestive
E. Blood
F. Genital
G. Urinary
H. Motor
I. Nervous
   1) Pallium
   2) Subpallium
   3) Basal ganglion
   4) Thalamus
   5) Subthalamus
   6) Lower brain stem centers
J. Endocrine system
K. Combinations of two or more systems
L. Unclassified
M. Unknown

1. Subclassified into particular structures involved
2. Subclassified according to type of destruction

IV. Prognosis
A. Able to adjust in ordinary environment
   1) Immediate recovery
   2) Delayed recovery
B. Able to adjust partially in ordinary environment
   1) Requires supervision
   2) Requires slight supervision (parole)
   3) Requires companionship
   4) Requires custody of relatives
C. Unable to adjust in ordinary environment
   1) Part time institutionalization or its equivalent
   2) Complete institutionalization
      a) Temporary
      b) Permanent

Under the old classification, a patient having a condition known as Kersakoff psychosis might have the peripheral neuritis accompanying it or he might have the peripheral condition without the mental syndrome. Its picture under the above classification would be:

I. Alcoholism.
II. Memory defect with confabulation.
III. Structural changes in the peripheral nerves.
IV. Requires permanent hospitalization.

Each of the above classes could be made more detailed, but it can be seen from this brief description that the conversant psychiatrist can determine quickly the entity with which he is dealing. It can be applied to behavior problems as follows:

I. Environmental situation, poverty, bad companions.
II. Restlessness, functional decrease.
III. Unknown structural change.
IV. Requires supervision.

In this way the subclassifications as well as the criteria deliminated can more closely picture the disease briefly than the simple use of names.